BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	
	)	
JOSEPHINE PHAM, M.D.	)	MBC File # 800-2014-0006232
	)	
	)	
Physician's & Surgeon's Certificate No. A 53882	)	
	)	
	)	
Respondent.	)	

ORDER CORRECTING NUNC PRO TUNC
CLERICAL ERRORS IN "ORDER DATE" AND "EFFECTIVE DATE"
PORTIONS OF DECISION

On its own motion, the Medical Board of California (hereafter "board") finds that there are clerical errors in the "order date" and "effective date" portions of the Decision in the above-entitled matter and that such clerical errors should be corrected.

IT IS HEREBY ORDERED that the order date and effective date contained on the Decision Order Page in the above-entitled matter be and hereby are amended and corrected nunc pro tunc as of the date of entry of the decision to read:

- "IT IS SO ORDERED: November 8, 2017."
- "This Decision shall become effective at 5:00 p.m. on December 8, 2017."

Dated: November 14, 2017

Kristina D. Lawson, J.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	
JOSEPHINE PHAM, M.D.	)	**Case No. 800-2014-006232**
	)	
Physician's and Surgeon's Certificate No. A 53882	)	
	)	
	)	
Respondent	)	
	)	

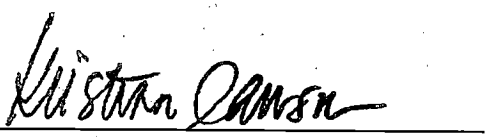
DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 8, 2017.

IT IS SO ORDERED: December 8, 2017.

MEDICAL BOARD OF CALIFORNIA



Kristina Lawson, J.D., Chair
Panel B

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JOSEPHINE PHAM, M.D.** 2307 Forest Avenue San Jose, CA 95128 **Physician's and Surgeon's Certificate No. A53882** Respondent.	Case No. 800-2014-006232 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Emily L. Brinkman, Deputy Attorney General.

2. Respondent Josephine Pham, M.D. (Respondent) is represented in this proceeding by attorney David Sheuerman, Esq., whose address is: 1033 Willow St., San Jose, CA 95125.

3. On or about January 18, 1995, the Board issued Physician's and Surgeon's Certificate No. A53882 to Josephine Pham, M.D. (Respondent). The Physician's and Surgeon's Certificate

was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2014-006232, and will expire on January 31, 2019, unless renewed.

JURISDICTION

4. Accusation No. 800-2014-006232 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 25, 2016. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2014-006232 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2014-006232. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2014-006232, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual

basis for the charges in the Accusation, and that Respondent hereby gives up her right to contest those charges.

11. Respondent agrees that if she ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2014-006232 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

12. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

13. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

14. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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15. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A53882 issued to Respondent Josephine Pham, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s) IV and V of the Act, for the first three years of probation.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or

cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Respondent shall immediately surrender Respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

2. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 25 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at

correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 50 hours of CME of which 25 hours were in satisfaction of this condition.

4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course

not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its

designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

7. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which

includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

8. NOTIFICATION.. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

9. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

10. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

11. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

12. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

13. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

14. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the

probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

15. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

16. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

17. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

18. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, David Sheuerman, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 7/20/2017

Pham, M.D.

JOSEPHINE PHAM, M.D.
Respondent

I have read and fully discussed with Respondent Josephine Pham, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 7/24/17

DAVID SHEUERMAN, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 7/24/2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

EMILY L. BRINKMAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2014-006232

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Josephine Pham, M.D.** 2307 Forest Avenue San Jose, CA 95128 **Physician's and Surgeon's Certificate No. A53882,** Respondent.	Case No. 800-2014-006232 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about January 18, 1995, the Medical Board issued Physician's and Surgeon's Certificate Number A53882 to Josephine Pham, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2017, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board,[1] under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states, in relevant part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care."

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[1] The term "Board" means the Medical Board of California. "Division of Medical Quality" or "Division" shall also be deemed to refer to the Board (Bus. & Prof. Code section 2002).

6. Section 725 of the Code states, in relevant part:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

7. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

8. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

9. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

RELEVANT DRUG INFORMATION

10. **Alprazolam**, also known by the trade name Xanax, is used for the management of anxiety disorders or for the short-term relief of anxiety symptoms. It is a dangerous drug as defined in Code section 4022 and a Schedule IV controlled substance as defined by Health and Safety Code section 11057 (d). Xanax has central nervous system (CNS) depressant effects and patients should be cautioned about using alcohol and other CNS depressant drugs at the same time. Addiction-prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving Xanax because of the predisposition of such patients to habituation and dependence.

11. **Adderall** is the trade name for mixed salts of a single-entity amphetamine product, a CNS stimulant used to treat Attention Deficit Disorder (ADD)/Attention-Deficit Hyperactivity Disorder (ADHD). It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined by Health and Safety Code section 11055(d). The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Amphetamines have been extensively abused. Tolerance, extreme psychological dependence, and severe social disability have occurred.

12. **Carisoprodol**, also known by the trade name Soma, is a muscle-relaxant and sedative. It is a Schedule III controlled substance as defined by Health and Safety Code section 11056 (e), a Schedule III controlled substance as defined by section 1308.13(e) of Title 21 of the

Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Since the effects of carisoprodol with alcohol, or other CNS depressants, or psychotropic drugs may be addictive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.

13. **Clonazepam**, also known by the trade name Klonopin, is an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by Health and Safety Code section 11057. It produces CNS depression and should be used with caution with other CNS depressant drugs.

14. **Dilaudid** is a trade name for hydromorphone hydrochloride. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined by Health and Safety Code section 11055(d). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution. Side effects include drowsiness, mental clouding, respiratory depression, and vomiting.

15. **Methadone hydrochloride** is a synthetic narcotic pain reliever with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined by Health and Safety Code section 11055(c). Methadone can produce drug dependence of the morphine type and, therefore, has the potential for abuse. Psychological and physical dependence can develop with repeated administration, and it should be prescribed and administered with the same degree of caution as with morphine.

16. **MS Contin** is a trade name for morphine sulfate controlled-release tablets. It is used for patients who require a potent pain relief of moderate to severe pain. Morphine is a dangerous drug as defined in section 4022 and is a Schedule II controlled substance as defined by Health and Safety Code section 11055(b)(1). Morphine can produce drug dependence and has the potential for being abused. Tolerance and psychological and physical dependence may develop on repeated administration.

17. **Norco** is a trade name for hydrocodone bitartrate with acetaminophen. Norco tablets contain 10 milligrams (mg) of hydrocodone bitartrate and 350 mg of acetaminophen (referred to

as Norco 10/325). Acetaminophen is a non-opiate, non-salicylate analgesic and antipyretic. Hydrocodone bitartrate is a semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022. Norco is a Schedule III controlled substance as defined by Health and Safety Code section 11056(e). Repeated administration of hydrocodone over a course of several weeks may result in psychic and physical dependence.

18. **Opana ER** is the trade name for oxymorphone. It is an opioid extended release medication for around the clock treatment of moderate to severe pain. It is a dangerous drug as defined in section 4022 and is a Schedule II controlled substance as defined by Health and Safety Code section 11055(b)(1)(N). Misuse of this medication can cause addiction, overdose, or death. It may be habit forming, even at regular doses. It can cause respiratory issues and requires regularly monitoring.

19. **Oxycodone with acetaminophen**, also known by the trade name Percocet, is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and is a Schedule II controlled substance as defined by Health and Safety Code section 11055(b)(1). Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for abuse.

20. **Oxycontin** is a trade name for oxycodone hydrochloride controlled-release tablets. It is a pure agonist opioid whose principal therapeutic action is pain relief. Other therapeutic side effects include anxiolysis, euphoria, and feelings of relaxation. It is a dangerous drug as defined in section 4022 and is a Schedule II controlled substance as defined by Health and Safety Code section 11055(b)(1). Respiratory depression is the chief hazard from all opioid agonist preparations. There is abuse potential similar to morphine.

21. **Promethazine hydrochloride** is a dangerous drug as defined in section 4022 and has antihistaminic, sedative, anti-motion sickness, antiemetic, and anticholinergic effects. It may be used as a preoperative sedative. The concomitant use of alcohol, sedative hypnotics (including barbiturates), general anesthetics, narcotics, narcotic analgesics, tranquilizers, or other CNS depressants may have addictive sedative effects and patients should be warned accordingly.

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22. **Valium** is a trade name for diazepam, a benzodiazepine used for the management of anxiety disorders. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by Health and Safety Code section 11057. It can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics).

23. **Zofran,** the trade name for ondansetron hydrochloride, is a dangerous drug as defined by section 4022. It is an anti-emetic and is generally used to prevent nausea and vomiting associated with chemotherapy, radiation therapy, or to prevent post-operative nausea and vomiting.

24. **Zolpidem Tartrate,** also known by the trade name Ambien, is a non-benzodiazepine hypnotic. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It is indicated for the short-term treatment of insomnia. It is a CNS depressant and should be used cautiously in combination with other CNS depressants. Any CNS depressant could potentially enhance the CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien.

RESPONDENT'S PRACTICE:

25. At all times relevant to this matter, Respondent practiced medicine in San Jose, California in a private practice. Respondent has been in a private internal medicine practice since she graduated from her residency program in 2000. Respondent is not board certified. Respondent received training in pain management during her residency program when she completed a three month elective course, but does not consider her practice a pain management practice.

26. Respondent uses a pre-printed progress note that contains a list of systems that Respondent can circle or check off if present, blank spaces to list current medications, an area for the patient's chief complaint, and Respondent's review of systems. There is also a line for the

patient's vital signs (height, weight, "T," blood pressure, pulse, and "RR"). The bottom portion of the form contains the "Impression & Plans" section for Respondent to complete.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts, and/or Excessive Prescribing of Controlled Substances, and/or Prescribing Without Appropriate Examination Based on the Care of Patient JC)

27. Respondent is subject to disciplinary action under Code sections 2234 [unprofessional conduct], 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 725 [excessive prescribing], and/or 2242 [prescribing without appropriate examination], in that Respondent engaged in unprofessional conduct in her care and treatment of Patient JC.[2] The circumstances are as follows:

28. On or about April 29, 2010, Patient JC, a then 37 year-old man, had his first appointment with Respondent at her medical practice. According to the progress note for the visit, Patient JC's medical history included a chronic leg wound from a dirt bike accident in 2007, Methicillin-Resistant Staphylococcus Aureus (MRSA), Attention Deficit Disorder (ADD), and anxiety. He had prior surgeries for a broken arm and "leg surgeries." The following medications were listed: 20 milligrams (mg) of Diazepam four times per day, 10 mg of Methadone three times per day, 80 mg of Oxycontin four times per day, eight mg of Zofran three times per day, 300 mg of Neurontin four times per day, and 30 mg of Oxycodone IR as needed for pain. Respondent also wrote that the Dilaudid no longer worked. Respondent cleaned JC's leg wound and provided him supplies for wound care. Respondent prescribed two mg of Klonopin four times per day for anxiety. For JC's leg pain she prescribed 30 mg of methadone (900 pills),[3] Oxycontin, oxycodone

[2] Initials are used to protect patient confidentiality. Respondent may learn the patient names during discovery.

[3] According to the Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) report, Respondent wrote Patient JC two prescriptions for methadone, both for 10 mg, not 30 mg as documented in the medical record. One prescription was for 660 pills and the second prescription was for 240 pills.

IR, and 600 mg of Neurontin four times per day. She did not document the quantity or instructions for the Oxycontin or oxycodone.[4] She also prescribed Zofran for nausea.

29. At the bottom of the April 29, 2010 progress report there is a handwritten note dated May 3, 2010, indicating Respondent prescribed mebendazole and praziquantel.[5] These are anti-worm medications. There is no explanation in the medical record why Respondent prescribed these two medications.

30. There is no documentation from this initial visit that Respondent discussed the risks and benefits of taking these medications, particularly at these high doses, with Patient JC.[6] Respondent failed to review and/or request medical records from Patient JC's prior medical provider(s) to determine the necessity for starting him on high doses of controlled substances. Respondent also failed to review a CURES report to establish the prior prescribing history of the patient. Respondent also failed to conduct and document any history of possible addiction or substance abuse history from the patient. Respondent also failed to discuss and document any alternative treatment or therapies besides starting Patient JC on high doses of controlled substances.

31. Respondent continued to see Patient JC for follow-up appointments through December 11, 2012. During these two years, Respondent documented three visits in 2010, four patient visits in 2011, and four visits in 2012. While Respondent only met with the patient approximately every three months, pharmacy records indicate that Patient JC filled his prescriptions monthly. Respondent admitted during the Board's investigation that she predated prescriptions for her patients, including JC.

32. On or about July 2, 2010, Respondent listed the medications Patient JC was taking, which now included 350 mg of Soma three times per day. Respondent noted that Patient JC was

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[4] According to the CURES report, Patient JC filled a 30 mg oxycodone (100 pills) prescription and an 80 mg Oxycontin (120 pills) prescription following the first appointment with Respondent.

[5] Both of these medications are dangerous drugs as defined by section 4022.

[6] According to certified pharmacy records, Patient JC was prescribed 10 mg of diazepam (120 pills), 10 mg of methadone (480 pills), eight mg of Zofran (30 pills), and 80 mg of Oxycontin (120 pills) on April 5 and 14, 2010 from other medical providers.

using a wheelchair. She refilled methadone, Oxycontin, and oxycodone for his left leg pain. There was no documentation that she conducted any examination beyond reviewing his vital signs, that she conducted any periodic review as to the effectiveness of the medications, or that she considered referring Patient JC to a specialist. She also prescribed Cialis for erectile dysfunction; however, there was no documentation in the medical record why this was requested, or that a medical history or evaluation was performed.

33. Between June and October 2010, the certified pharmacy records indicate that Patient JC filled the following prescriptions monthly, which were all prescribed by Respondent: 30 mg of oxycodone (120 pills), 10 mg of methadone (900 pills), 80 mg of Oxycontin (100 pills), and 350 mg of Soma (90 pills).

34. On or about October 8, 2010, Respondent refilled all of Patient JC's medications for three months. Respondent also increased the Oxycontin to five pills per day. Respondent documented that Patient JC was having 10 out of 10 pain in his leg because he continued having wound care problems. According to pharmacy records, Patient JC filled three Oxycontin prescriptions during October totaling 164 pills. There was no documentation that Respondent conducted any examination beyond reviewing Patient JC's vital signs, that she conducted any periodic review as to the effectiveness of the medications, or that she considered referring Patient JC to a specialist.

35. On or about January 7, 2011, Respondent noted during this patient visit that he was doing better, but his pain was still seven out of ten. She refilled all of the medications. Respondent also indicated she was adding 40 mg of Opana ER, twice daily (60 pills); however, Patient JC did not fill a prescription until April 2011. She wrote that she was providing prescriptions to Patient JC for the next three months.

36. On or about April 8, 2011, Respondent wrote on the progress note for this visit that Patient JC broke his 2nd finger. She wrote "surgery" but it is not clear if this meant the patient had surgery or would be having surgery for the injury. Respondent also wrote that Patient JC could not afford to fill the previous Opana ER prescription so she wrote a new prescription for this medication. She also noted that his pain was a five out of 10 with pain medications and 10 out of

10 without pain medications. She did not document what medications were being prescribed other than the Opana ER, nor did she document the effect of the medications on the patient, whether he was having any side effects, or that she considered referring him to a specialist.

37. Between April 2011 and July 2011, Patient JC filled the following prescriptions every month: 30 mg of oxycodone (120 pills), 10 mg of methadone (900 pills), 80 mg of Oxycontin (120 pills),[7] two mg of clonazepam (240 pills), and 350 mg of Soma (90 pills). Patient JC also filled the Opana ER prescription in April 2011.

38. On or about July 8, 2011, Respondent noted that Patient JC was present for his three month follow-up appointment. She documented that his second right finger was deformed following surgery and that his leg wounds were healing, but his pain was still severe. She further noted that he was using a cane and there was a rotten flesh smell coming from his leg wound. Respondent documented that she decreased the Oxycontin and the oxycodone to 100 pills; however, she prescribed the exact same amount of Oxycontin (120 pills). Respondent failed to document the reason for the decrease in the oxycodone.

39. Between August 2011 and March 2012, Patient JC had two appointments with Respondent. During this same period, she refilled the oxycodone, methadone, Oxycontin, Soma, and clonazepam[8] at the same dose as the July 2011 prescriptions.

40. On or about April 6, 2012, Respondent documented on the progress note for the appointment with Patient JC that "leg wound healing but still in pain." She also documented that he was complaining of increased depression. She also wrote that a foul smell was coming from Patient JC's leg bandages. Respondent did not document a treatment plan or evaluation of the wound and whether Patient JC was being treated by another provider for the leg wound. She wrote that she was refilling all of the medications but not the dose or instructions. According to certified pharmacy records, she refilled all of the medications at the same dose and instructions

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[7] Patient JC did not fill a prescription for Oxycontin in June 2011.

[8] On or about November 9, 2011, Patient JC filled a clonazepam prescription for 100 pills and refilled the same prescription for 240 pills on November 28, 2011. There is no documentation in the patient's medical record why Respondent increased the clonazepam for November.

with the exception of the oxycodone that was increased to 125 pills. There is no documentation in the record why she increased the oxycodone.

41. On or about July 6, 2012, Patient JC went for his three month follow-up appointment with Respondent. On the progress note, Respondent documented that his pain was stable and he had no new problems. She also noted that he got into college for cinematography. She noted that he had not had any falls, was not drowsy, and was not sleepy in the daytime. Under the list of current medications she listed all of the medications he had been on since 2010, but also wrote "Dextroamphet[9] 15 mg TID [three times per day] for school." In the "Impression and Plans" section of the progress note she indicated she was refilling all of his medications, but she failed to indicate the dose or instructions. She also wrote that she was prescribing "Dexedrin 15 mg TID X 3 m [months]" for ADD. According to the certified pharmacy records, Respondent filled all of the medications at the same dose previously prescribed, including the amphetamine prescription.

42. October 5, 2012, during Patient JC's follow-up with Respondent, she indicated that he had been kicked out of school because the patient's father told the school Patient JC was a heroin addict. She further noted that she discussed reducing his medications with him; however, she did not document the plan for reducing his medications. Respondent reissued prescriptions for all of the same medications previously prescribed at the same dosage with the exception of the methadone prescription. She prescribed him 450 pills, rather than the usual 900 pills. She also documented that Patient JC was going to be tested for ADD.

43. On or about December 11, 2012, Respondent wrote a letter to Patient JC terminating him as a patient because he failed to get a urine test as she requested on November 21, 2012; however, according to the medical records, Patient JC was last in her office on October 5, 2012.

44. Despite terminating Patient JC from her practice, she wrote him prescriptions dated January 4, 2013 for 10 mg of methadone (450 pills), 80 mg Of Oxycontin (60 pills), two mg of Klonopin (120 pills), and 350 mg of Soma (90 pills). According to pharmacy records and

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[9] This is short for dextroamphetamine, a CNS stimulant used to treat narcolepsy and ADHD.

CURES reports, Patient JC filled these prescriptions from Respondent through March 2013, despite her termination of him as a patient in December of 2012.

45. Respondent's care of Patient JC constitutes unprofessional conduct through gross negligence, and/or repeated negligent acts, and/or prescribing without an appropriate examination, and/or inappropriate/inadequate medical record keeping, and/or excessive prescribing of controlled substances, including, but not limited to the following:

a. Respondent prescribed large amounts and high doses of opioids without adequate or appropriate examination and medical indication;

b. Respondent failed to conduct and document screening measures before prescribing high doses of controlled substances;

c. Respondent failed to conduct a review of past medical records or CURES reports to determine the necessity for starting Patient JC on high doses of controlled substances;

d. Respondent failed to conduct any history of possible addiction or substance abuse history from the patient;

e. Respondent also failed to discuss and document any alternative treatment or therapies besides starting Patient JC on high doses of controlled substances;

f. Respondent prescribed 700-800 times above the morphine equivalent dose (MED) per day and failed to thoroughly screen and monitor Patient JC;

g. Respondent failed to refer Patient JC to a pain management specialist, despite prescribing him high doses of controlled substances;

h. Respondent failed to establish and review any functional goals of her treatment of Patient JC;

i. Respondent simultaneously prescribed multiple opioids, benzodiazepines, Soma, and stimulants;

j. Respondent failed to conduct and document any conversation with Patient JC about the risks and benefits of not only taking high doses of controlled substances, but also combining multiple opioids, benzodiazepines, stimulants, and Soma concurrently;

k. Respondent failed to document informed consent related to the risks and benefits of using controlled substances;

l. Respondent pre-dated controlled substances prescriptions.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts, and/or Excessive Prescribing of Controlled Substances, and/or Prescribing Without Appropriate Examination Based on the Care of Patient AN)

46. Respondent is subject to disciplinary action under Code sections 2234 [unprofessional conduct], 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 725 [excessive prescribing], and/or 2242 [prescribing without appropriate examination], in that Respondent engaged in unprofessional conduct in her care and treatment of Patient AN. The circumstances are as follows:

47. On or about July 9, 2009, Patient AN, a then 31 year-old male, went to Respondent's office for treatment. Respondent listed his chief complaint as low back pain from a snowboarding accident in November of 2008 and a subsequent work injury in February 2009. Respondent listed his work as a cabinet/door installer. She also listed his current medications as 10/660 mg of Vicodin (240 pills). In the "Impressions and Plans" section of the progress note Respondent prescribed 10/325 mg of Norco (240 pills), physical therapy if there is no change, and allergy medication. She also wrote "discussed addiction, tolerance, no early refills for any reason, only one physician prescribing meds."

48. There is no documentation from this initial visit that Respondent discussed the risks and benefits of taking these medications, particularly at these high doses, with Patient AN other than the brief documentation that she "discussed addiction, tolerance." Respondent failed to review and/or request medical records from Patient AN's prior medical provider(s) to determine the necessity for starting him on high doses of controlled substances, including reviewing a CURES report to establish the prior prescribing history of the patient. Respondent also failed to conduct and document any history of possible addiction or substance abuse history from the patient. Respondent also failed to discuss and document any alternative treatment or therapies

besides starting Patient AN on high doses of controlled substances.

49. Respondent next saw Patient AN on or about October 7, 2009. Patient AN complained that he was having back pain all the way down both legs, the pain was a ten out of ten without pain medications, and an eight out of ten with pain medications. In the "Impression & Plans" section of the progress note Respondent prescribed "Oxycontin 80 BID" for low back pain and with a refill of Norco; however, Respondent failed to indicate the dosage or instructions for the Norco prescription.

50. On or about November 2, 2009, Patient AN saw Respondent for another follow-up visit. Respondent documented that Patient AN lost his Oxycontin and was taking more Norco than prescribed. She failed to document his actual intake. She also noted that his low back pain was worse because of work as a cabinet maker. She further noted that he was not drowsy, was not sleepy during the day, and was alert. In the "Impression & Plans" section, Respondent wrote something about Patient AN's shoulder but the record is not legible. She prescribed 350 mg of Soma. She did not document what other medications she prescribed. Respondent wrote "Again discussed no early refills for any reasons." There is no discussion or documentation that Respondent advised Patient AN of the risks in taking multiple controlled substances, or that she offered or considered any alternative treatment for his care beyond pain medication.

51. On or about March 25, 2010, Respondent saw Patient AN for his two month follow-up appointment. Patient AN indicated he was going to have surgery for a deviated septum and had increased anxiety around noontime for the past two to three months. Respondent listed the "current medications" as Oxycontin, Norco, and Allegra. Under the "Impression & Plans" portion of the progress note, Respondent wrote that she was prescribing a selective serotonin reuptake inhibitor (SSRIs), Cymbalta, for anxiety and 0.25 mg of Xanax; however, Respondent failed to clearly document the quantity prescribed. She also simply wrote "LBP [low back pain] – refill" rather than list the actual medications she refilled along with the dose and instructions. Respondent also failed to document any discussion of the anxiety of the patient.

52. On or about June 25, 2010, at the next appointment with Patient AN, Respondent wrote that his pain was stable and he was able to work, but there was no discussion about

reducing his pain medication. Rather, Respondent wrote that she was refilling his Oxycontin for the next three months. Patient AN also reported that Lexapro was too weak so Respondent increased it to 20 mg every day. Respondent also scratched out 0.25 mg Xanax and wrote one mg "not sleepy;" however, there is nothing explaining this note or why she increased the Xanax.

53. On or about December 20, 2010, Patient AN returned for a three month follow-up visit and reported that he broke his right fibula and dislocated the ankle, requiring a cast and then walking boot. Respondent wrote that his pain was controlled, but there was no discussion or documentation about trying to reduce Patient AN's pain medications. Respondent only wrote that she was refilling the Oxycontin for the next three months. She did not indicate the dose or instructions. Since the initial appointment, Patient AN was also regularly filling Norco prescriptions (240 pills) each month, but Respondent did not document those prescriptions in the patient's medical records.

54. On or about March 21, 2011, Patient AN reported during a patient visit with Respondent that the Oxycontin was no longer working and he was in increased pain because of the right leg injury. Respondent only listed the current medications as Ambien and Xanax, despite pharmacy records indicating Respondent was still prescribing Oxycontin and Norco to Patient AN. Respondent also wrote "zero muscle spasm paraspinal of LS." Despite documenting that Patient AN was not having muscle spasms, Respondent increased the Soma to 350 mg three times per day (90 pills); however, Respondent prescribed this amount since October 2010.[10] Respondent also wrote that she was refilling 80 mg of Oxycontin (60 pills) but she made no mention of the continued Norco prescription.

55. Respondent continued prescribing Norco (240 pills), Oxycontin (60 pills), Soma (90 pills), Ambien (30 pills), and Xanax (60 pills) monthly to Patient AN.[11] There was never any documentation or discussion to refer him to a pain specialist or to reduce his medications. There

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[10] According the certified pharmacy records, Respondent began prescribing 350 mg of Soma to Patient off and on starting in November of 2009. Originally she prescribed 30 pills at a time, but that increased to 90 pills in October 2010.

[11] According to certified pharmacy records, Patient AN did not fill any Xanax or Ambien prescriptions between June 2011 through November 2011.

was also no documentation or discussion about the serious risks of being on these medications concurrently. By August 2011, Respondent wrote that his low back pain and right leg pain were "stable." There was no documentation or discussion in the medical records that Respondent conducted any type of periodic review and assessment of her treatment plan of Patient AN, including whether the pain medications were helping him.

56. On or about December 13, 2011, Patient AN reported at his three month follow-up appointment with Respondent that he was not able to sleep because his arms kept moving. He also indicated he was having increased low back pain because of heavy lifting at work. Respondent listed his current medications as: 350 mg of Soma, 80 mg of Oxycontin, 10/325 mg of Norco, one mg of Xanax, 10 mg of Ambien, and the prescription for 600 mg of Ibuprofen was not working. Under the "Impression & Plans" portion of the progress note, Respondent indicated that she was prescribing 0.25 mg of Requip at bedtime for "restless arm." She also wrote that she was refilling all of his medications for three months.

57. On or about January 12, 2012, Patient AN went to Respondent with complaints of a sore throat for the previous two days. She documented that several conditions as being negative; however, her writing is illegible making it next to impossible to determine what conditions she ruled out. Respondent also documented "took Adderall as a kid for ADD, still having trouble focus on work = stress ↑." Respondent did not review any prior medical records to verify any prior ADD treatment or diagnosis, nor did she order any testing to confirm the diagnosis. Besides providing Patient AN an antibiotic for the sore throat, she prescribed 20 mg of Adderall every day before noon. She did not document the quantity of pills she prescribed. At the bottom of the progress note there is a handwritten note dated February 10, 2012, "Adderall 20 mg gel works better." There was no further documentation explaining this note. According to certified pharmacy records, Patient AN began receiving 20 mg of amphetamine salt tablets (30 pills) on February 12, 2012.

58. On or about March 13, 2012, Patient AN saw Respondent for a follow-up visit. He reported that the Adderall wears off at approximately seven a.m. He also reported that the low back pain and ankle pain were "unchanged." Respondent noted that his blood pressure had

increased, but also wrote that the patient was not reporting any heart palpitations or insomnia. Respondent further documented that Patient AN remained on 20 mg of Adderall (once per day), 80 mg of Oxycontin (twice a day), 10/325 mg of Norco (eight pills per day), 10 mg of Ambien every night, 350 mg of Soma (three pills per day), and one mg of Xanax (four pills per day). Respondent wrote that she was only refilling the Oxycontin, and was increasing the Adderall to twice per day. There was no other notation about what medications she refilled for Patient AN. According to certified pharmacy records she refilled the Ambien (30 pills), Soma (90 pills), Norco (240 pills), and amphetamine salt (60 pills). Respondent also failed to make any treatment plan or assessment connected to her notation that Patient AN's blood pressure was elevated.[12]

59. On or about June 5, 2012, Patient AN reported during a follow-up visit with Respondent that for the past three days the room was spinning, he was nauseous, and it was worse with head movement. There was no discussion documented connected to Patient AN's chronic pain conditions. Respondent prescribed medications for allergies and vertigo, and refilled medications for anxiety, ADD, and chronic pain. There was no documentation or assessment as to how Patient AN was functioning on the current medications, whether he was suffering any side effects, or whether he was still in pain. Respondent also indicated she was increasing the Adderall to three times per day (90 pills) and the Xanax to two mg every eight hours (90 pills). She refilled the Ambien, Soma, Norco, and Oxycodone at the same dose as previously prescribed. There was no documentation in the medical record why Respondent increased the Adderall or the Xanax, or that she discussed the risks and benefits of increasing these medications, particularly when he was taking so many controlled substances at high doses.

60. Between August 2012 and March 2013, according to certified pharmacy records, Patient AN filled the following prescriptions written by Respondent each month:[13] two mg of

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[12] The following month, Patient AN reported that he would no longer have insurance. Respondent wrote that she was switching his medications from Oxycontin to 30 mg of oxycodone (270 pills, three pills three times per day).

[13] The only exception is that Patient AN stopped filling the Ambien on August 2012. Respondent indicated in the December 7, 2012 progress note that he was no longer taking the Ambien because it was not working.

Xanax (90 pills);[14] 350 mg of Soma (90 pills);[15] 10/325 mg of Norco (240 pills);[16] 30 mg of oxycodone (270 pills);[17] and 30 mg of amphetamine salt (90 pills)[18]. During this period, Respondent saw Patient AN on August 22, 2012, September 5, 2012, November 9, 2012,[19] December 7, 2012, and March 8, 2013. There is no documentation in the progress notes that indicated Respondent reviewed CURES reports, discussed the risks and benefits of using multiple high doses of controlled substances, conducted any periodic review of the effectiveness of the medications, considered the side effects, or referred Patient AN to a specialist to deal with his pain management.

61. On or about March 8, 2013, Respondent treated Patient AN at a follow-up appointment. Patient AN indicated his low back pain was controlled and there had not been any change in his condition. He also reported having left jaw pain, which was helped by the Soma. Respondent listed his medications as Norco, Soma, and Xanax; however, Patient AN also continued taking the amphetamine salt prescribed by Respondent. Respondent prescribed

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[14] Patient AN filled three different prescriptions for two mg of Xanax (90 pills) at two different pharmacies on November 1 and 9, 2012. Starting in January 2013, Patient AN filled one mg of Xanax (180 pills) prescription monthly. There was no progress note documenting a reason for dosage change or increase in quantity, nor was there a progress note for January 2013 between Respondent and Patient AN.

[15] Patient AN filled two prescriptions for Soma during the month of October (each had a different prescription number), and he did not fill a Soma prescription in November. On the December 7, 2012 progress note, Respondent indicated the Soma was not needed and causing the restless leg syndrome; however, Patient AN continued to fill prescriptions for it in this time period.

[16] Patient AN filled two prescriptions for Norco during October, receiving 480 pills in one month (the original and a refill). He then filled two different Norco prescriptions in November at two different pharmacies, again receiving 480 pills in one month. He repeated this behavior in January 2013.

[17] Patient AN filled three oxycodone prescriptions (each had a different prescription number) in November at two different pharmacies two days apart, receiving 810 pills in one month.

[18] Starting in October 2012, Patient AN began filling 30 mg of amphetamine salt (90 pills) each month. This was an increase from 20 mg; however, there was no progress note documenting a reason for the increase in dosage, nor was there a progress note for October 2012 between Respondent and Patient AN. In November, Patient AN filled three prescriptions at two different pharmacies, receiving a total of 270 pills for the month.

[19] According to Respondent's progress note for the November 9, 2012 visit, Patient AN told her that someone broke into his car and stole all of his medications and he had been without medications for three days. The police report provided was a one page report that Patient AN's car window had been pried open but there was no mention that medications were stolen.

medication for the jaw pain; however, the medication is not legible. She also refilled the oxycodone, amphetamine, and Soma.[20]

62. On or about April 5, 2013, Patient AN returned for a follow-up visit. During this appointment he completed a new two page pre-printed form titled "Patient Comfort Assessment Guide." The document has 11 questions requiring the patient to either circle a description of number categorizing his or her pain level. Only the first page of the form is dated and the forms were not in order in Patient AN's chart, making it impossible to determine which second page belonged to which visit. Furthermore, Patient AN did not complete this form at many of his subsequent visits and Respondent did not document this information in the regular progress note.

63. Between March 2013 and December 2013, Respondent saw Patient AN every month for follow-up appointments. Patient AN's medications remained the same: one mg of Xanax (90 pills), 350 mg of Soma (90 pills), 10/325 mg of Norco (240 pills), 30 mg of oxycodone (270 pills), and 30 mg of amphetamine salts (90 pills).[21] When Patient AN completed the "Patient Comfort Assessment Guide," he completed them identically as to the previous forms, including the same areas where he blacked out something next to the word "hydrocodone." The only variation in the form is the handwritten date on the first page of the form. During this period, there was no documentation or discussion in the medical records that Respondent conducted any type of periodic review and assessment of her treatment plan of Patient AN, including whether the pain medications were helping him.

64. On or about December 27, 2013, Patient AN returned to Respondent's office for an appointment. His chief complaint was a sinus infection. Respondent wrote "new pain meds regimes not controlling the pain so ↑ Oxycontin 2 pills twice per day & out of Roxicodone/Norco." Respondent noted his current medications as two mg of a nonsteroidal anti-inflammatory drug (NSAID) Celebrex; 30 mg of Oxycontin (60 pills); 30 mg of Roxicodone (180

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[20] Respondent did not document that she prescribed Soma; however, Patient AN filled his usual prescription. Patient AN also filled the original and one refill prescription of Norco in March.

[21] The progress note from August 2, 2013 contains Respondent's handwritten statement that she required Patient AN to get a urine drug test or she would terminate him as a patient.

pills); and 10/325 mg of Norco (180 pills).[22] In the "Impression & Plans" portion of the progress note, Respondent prescribed antibiotics; added Phenergan with codeine cough syrup; increased the Oxycontin to 80 mg (60 pills), 30 mg of Oxycontin (60 pills), added four mg of Dilaudid (180 pills), and wrote that oxycodone and Norco were discontinued. Despite the notation that she discontinued Norco and oxycodone, Patient AN continued to fill Norco prescriptions through April 2014 and oxycodone through June 2014.

65. On or about February 7, 2014, Patient AN reported to Respondent during a follow-up appointment that the Dilaudid caused dehydration and nausea. Respondent only documented that Patient AN was taking Adderall and Xanax, but he was still taking Oxycontin, Soma, Norco, and oxycodone. Respondent documented that Patient AN's right ankle was tender on examination and she referred him to another doctor, but the record did not list the specialty. Respondent added 20 mg of oxycodone (180 pills); 30 mg of oxycodone (180 pills); refilled 80 mg of Oxycontin (60 pills); 10/325 of Norco (180 pills); and Adderall (without documenting the dosage or instructions). Respondent also documented that she reduced the Dilaudid to four mg three times per day (90 pills).

66. On or about May 13, 2014, Patient AN had a follow-up appointment with Respondent. For the first time since she began treating Patient AN, Respondent ordered an MRI for Patient AN's lower back, and recommended massage and chiropractic care in addition to continuing Patient AN on controlled substances. Patient AN complained of increased leg pain radiating down his legs. Patient AN denied suffering any recent injury to explain the increased pain. The only medication Respondent listed were 400 mg of Motrin even though Patient AN was taking Xanax (180 pills), 20 mg of oxycodone (180 pills), 30 mg of oxycodone (180 pills), 30 mg of amphetamine salt (90 pills), and four mg of Dilaudid (90 pills). Respondent wrote that she discontinued Dilaudid, Norco, and Oxycontin and refilled 30 mg of oxycodone (480 pills) and 20

[22] According to certified pharmacy records, Patient AN was also receiving one mg of Xanax (180 pills) and 30 mg of amphetamine salts (90 pills), which Respondent did not document.

mg of oxycodone (480 pills).[23] Respondent failed to document that she also continued Patient AN on the amphetamine.

67. Patient AN's last visit with Respondent occurred on or about June 6, 2014. According to the progress note, Respondent wrote that Patient AN's urine drug test was positive for cocaine and she terminated him as a patient; however, the test results were not in the medical records produced by Respondent. Respondent refilled the 30 mg of oxycodone (480 pills) and 30 mg of amphetamine (90 pills). She provided him a list of possible physicians to take over his care. According to pharmacy records, Patient AN also filled a prescription for Xanax, which she did not document.

68. Respondent's care of Patient AN constitutes unprofessional conduct through gross negligence, and/or repeated negligent acts, and/or prescribing without an appropriate examination, and/or inappropriate/inadequate medical record keeping, and/or excessive prescribing of controlled substances, including, but not limited to the following:

a. Respondent prescribed large amounts and high doses of opioids without adequate or appropriate examination and medical indication;

b. Respondent failed to document conducting screening measures before prescribing high doses of controlled substances;

c. Respondent failed to conduct a review of past medical records or CURES reports to determine the necessity for starting and maintaining Patient AN on high doses of controlled substances;

d. Respondent failed to conduct and document any history of possible addiction or substance abuse history from the patient;

e. Respondent also failed to discuss and document any alternative treatment or therapies besides starting Patient AN on high doses of controlled substances;

f. Respondent prescribed 800 times above the morphine equivalent dose (MED) per day and failed to thoroughly screen and monitor Patient AN;

[23] Besides filling the two new oxycodone prescriptions for 480 pills, Patient AN also filled a third oxycodone prescription for 180 pills.

g. Respondent failed to refer Patient AN to a pain management specialist, despite prescribing him high doses of controlled substances;

h. Respondent failed to establish and review any functional goals of her treatment of Patient AN;

i. Respondent simultaneously prescribed multiple opioids, benzodiazepines, Soma, and stimulants;

j. Respondent failed to taper Patient AN off of the Soma, benzodiazepines, or stimulants;

k. Respondent failed to refer Patient AN for specialty medical services, including psychiatry or neurology;

l. Respondent continued to prescribe high doses of controlled substances despite evidence of aberrant behavior (lost or stolen prescriptions and positive urine tests) and in spite of Patient AN's lack of functional improvement;

m. Respondent pre-dated controlled substances prescriptions.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Act, and/or Excessive Prescribing of Controlled Substances, and/or Prescribing Without Appropriate Examination Based on the Care of Patient DM)

69. Respondent is subject to disciplinary action under Code sections 2234 [unprofessional conduct], 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 725 [excessive prescribing], and/or 2242 [prescribing without appropriate examination], in that Respondent engaged in unprofessional conduct in her care and treatment of Patient DM. The circumstances are as follows:

70. On or about February 22, 2011, Patient DM, a then 32 year-old male, began seeing Respondent as his primary care provider. Respondent wrote that he was diagnosed with fibromyalgia in 2012 and had a history of migraines. On the pre-printed progress note, Respondent circled arthralgia, back problems, and myalgia under the section labeled "MUSC." Respondent also wrote that he was currently taking 800 mg of Ibuprofen and 10/325 mg of Norco.

Respondent did not document a treatment plan or assessment of Patient DM during this visit. According to certified prescription records, Respondent began prescribing 10/325 mg of Norco (90 pills) every month through May 2012; however, she did not document this in the medical records. Respondent did not employ any screening measures to assess Patient DM's need for controlled substance, including reviewing previous medical records or reviewing CURES reports. Respondent also failed to conduct a substance abuse/addiction history of Patient DM before prescribing controlled substances. Respondent also failed to establish any treatment goals.

71. On or about June 17, 2011, Patient DM returned to Respondent's office with the chief complaint of gastric reflux at night. Respondent noted that she prescribed medications for both GERD and fibromyalgia. She also listed prescribing ibuprofen and Norco (150 pills) for joint pain; however, she did not document the reason she increased the Norco from three pills per day to five pills per day.

72. On or about September 23, 2011, Respondent saw Patient DM for a follow-up appointment for his fibromyalgia. According to the notes, Patient DM fell off of a ladder from the second story while at work on July 21, 2011 and injured his back. He had x-rays of his back and was being treated by worker's compensation doctors. Respondent listed that he was off of work through January 1, 2012. She noted pain radiating down Patient DM's left leg and spasms in his back. She noted that the patient could not afford an MRI. She refilled his medications, including the Norco; however, according to the certified pharmacy records Patient DM began filling two prescriptions a month of Norco for 150 pills each, totaling 300 pills a month (prescribed by Respondent). Respondent did not document the reason for the increase in the medication or that she discussed the risks and benefits of taking controlled substances with Patient DM. Respondent also did not document whether she was coordinating Patient DM's care with his worker's compensation doctors.

73. On or about January 13, 2012, Patient DM returned for a follow up appointment with Respondent. Patient DM reported that the Norco did not always work, his pain increased in the morning and when he was not on medications. Respondent added 15 mg of oxycodone (30 pills) and refilled the Norco for three months. According to certified pharmacy records, Patient DM

filled both prescriptions, including two Norco (150 pills) prescriptions. Respondent failed to discuss and document the risks and benefits of taking Norco and oxycodone simultaneously.

74. Between February 2012 and May 2012, according to the certified pharmacy records, Patient DM filled two Norco (150 pills) prescriptions every month, with the exception of April, when he only filled one prescription for 150 pills. In March 2012, Respondent increased Patient DM's 15 mg of oxycodone to 90 pills to last the next three months. But in April 2012, Patient DM filled a prescription for 30 mg of oxycodone (90 pills). There is no documentation in the medical record why Respondent increased the dose.

75. On or about May 16, 2012, Patient DM saw Respondent for a follow-up appointment for prescriptions refills and blood work. Respondent wrote that his migraines and fibromyalgia were improved and he stopped taking the Norco because the oxycodone worked. Respondent wrote in the "Impression & Plans" section that she increased the medication for migraines and fibromyalgia, increased the oxycodone to 360 pills (for three months), and discontinued the Norco. According to certified pharmacy records, Patient DM filled 150 pills of Norco prescribed by Respondent on May 1 and again on May 23. He also filled the three month supply of oxycodone.

76. On or about June 11, 2012, during Patient DM's next appointment with Respondent he indicated he was hospitalized following chest pain during a treadmill test. He also stated he lost all of his medications on the way to the hospital. Respondent refilled his oxycodone prescription (360 pills) for three months with a note "refill but last time for lost meds."

77. On or about July 25, 2012, at Patient DM's follow-up appointment, he informed Respondent that he took all of his oxycodone in one month because he was having kidney stone pain. Respondent also documented that on July 3, 2012 he was having heart palpitations and light headedness so he drove himself to the emergency room but on the way there he rear ended another vehicle. Respondent refilled medications for his arrhythmia and kidney stones, and also refilled the oxycodone for one month; however she did not document the quantity or instructions. According to the certified pharmacy reports, Patient DM filled 30 mg oxycodone (120 pills).

78. In August 2012, Respondent saw Patient DM on the 17th and 30th. Respondent reported that his low back pain was slightly worse following his car accident and his heart palpitations had decreased in the past two weeks. Respondent refilled the medications for low back pain for one month; however she failed to document the medication, dose, and instructions. Respondent refilled 30 mg of oxycodone (120 pills) on August 17. During the visit on August 30, 2012, Patient DM reported that his low back pain increased with sitting, standing, and walking. Respondent documented that she completed disability paperwork for Patient DM as well. Respondent wrote that she increased the oxycodone to six pills per day (180 pills) and refilled the medication for three months (540 pills), which Patient DM filled that day.

79. On or about October 5, 2012, Patient DM returned to Respondent's office for a follow-up appointment. He again reported that he took more oxycodone than prescribed because he had another "kidney stone attack." Respondent refilled his oxycodone early for 180 pills and post-dated the prescription for October 15, 2012.

80. On or about November 9, 2012, Patient DM reported during his follow-up appointment that his pain was two out of ten while on pain medications and nine out of ten when not on the pain medication. Respondent noted "no early refills for any reason" on the progress note, yet still prescribed three months of oxycodone (540 pills) during the visit.

81. On or about February 8, 2013, Respondent documented that Patient DM's low back pain was stable, his body pain was tolerable, and he was finally able to work again. Respondent refilled the oxycodone (180 pills).

82. On or about March 8, 2013, Patient DM reported that his body pain was stable but was having muscle spasms and wanted a muscle relaxer during his appointment with Respondent. Respondent refilled the oxycodone (180 pills) and prescribed five mg of Valium (30 pills) for the muscle spasms. Respondent failed to discuss and document the risks and benefits of taking an opiate and a benzodiazepine simultaneously.

83. Between April 2013 to February 2014, Respondent saw Patient DM monthly and prescribed 30 mg of oxycodone at amounts between 180 pills to 245 pills per month. She also prescribed ten mg of Valium between 30 pills to 36 pills per month. During these monthly

appointments Patient DM regularly reported that his pain was stable or controlled.[24] There was no discussion or documentation about referring Patient DM to a pain specialist or that she evaluated Patient DM's functional goals while on the medications.[25]

84. During Patient DM's appointment on August 2, 2013, Respondent wrote in the progress note that she required him to get a urine test or she would discharge him from the practice. The test results were positive for opiates and oxycodone; however, medical and pharmacy records showed that Patient DM was also taking Valium. Respondent failed to discuss and document with Patient DM whether or not he was in fact taking the Valium and why it might not have shown up in the urine screen. This was the only urine screen Respondent ordered during her treatment of Patient DM.

85. On or about March 7, 2014, Respondent saw Patient DM for a follow-up appointment. He reported that his body pain was "ok," his low back pain was a two out of ten on medications, and an eight out of ten without medications. Respondent refilled the oxycodone (180 pills). She noted that his current medication included Valium, however, in the "Impression & Plans" portion of the progress note failed to document any plan for this medication. According to certified pharmacy records, Patient DM no longer filled prescriptions for Valium after his last prescription in February 2014.[26]

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[24] Sometime in early 2013, Respondent began having Patient DM sporadically complete a two page "Patient Comfort Assessment Guide." However, the second page was not dated and the records were not kept together making it impossible to determine which forms belonged to which progress notes. Additionally, the information completed by Patient DM each month is identical. For example, the same words for describing his pain are circled on each form, the same pain levels are circled, and Patient DM wrote the exact same thing for "what makes your pain better? Sitting in a Jacuzzi or hot pad" and for "what makes your pain worse? Standing or sitting for long periods." The only different information is the date on the first page of the forms. For the second page (nine copies), there is the same hand written note on each copy that states "my back pain wakes me up in the middle of the night" and all of the pain selections (numbered between zero to ten) are also circled the same each month.

[25] During this period, Respondent prescribed Patient DM more than the 180 pills of oxycodone or 30 pills of Valium on four occasions; however, she does not document the basis for the change. For example, for the October 4, 2013 visit, Respondent documented that she was refilling his medications for 36 days, but does not explain the need to change from prescribing for 30 days. On December 6, 2012, she prescribed 228 pills of oxycodone and 38 pills of five mg Valium, but does not explain the change.

[26] Respondent continued to document Valium under the "current medication" list at subsequent visits.

86. Between April 2014 and October 2014 (the last progress note provided by Respondent), she continued to prescribe 30 mg of oxycodone (180 pills to 245 pills) each month.[27] During the monthly progress notes, Patient DM continued to report that his pain was stable and/or his pain was controlled, he was able to exercise, and to work at a desk job. Respondent failed to discuss and document that she reviewed Patient DM's functional goals as it related to any overall treatment goals.

87. Respondent's care of Patient DM constitutes unprofessional conduct through gross negligence, and/or repeated negligent acts, and/or prescribing without an appropriate examination, and/or inappropriate/inadequate medical record keeping, and/or excessive prescribing of controlled substances, including, but not limited to the following:

a. Respondent prescribed large amounts and high doses of opioids without an adequate or appropriate prior examination or medical indication;

b. Respondent failed to document conducting screening measures before prescribing high doses of controlled substances;

c. Respondent failed to conduct a review of past medical records or CURES reports to determine the necessity for starting Patient DM on high doses of controlled substances;

d. Respondent failed to conduct and document any history of possible addiction or substance abuse history from the patient;

e. Respondent prescribed 270 times above the morphine equivalent dose (MED) per day and failed to thoroughly screen and monitor Patient DM;

f. Respondent failed to refer Patient DM to a pain management specialist, despite prescribing him high doses of controlled substances, and despite numerous signs that Patient DM was abusing or diverting his medication;

g. Respondent failed to establish and review any functional goals of her treatment of Patient DM;

[27] According to CURES reports, Respondent continued to prescribe 30 mg of oxycodone (180 pills to 240 pills) to Patient DM through September 5, 2015.

h. Respondent simultaneously prescribed multiple opiates with benzodiazepines and failed to discuss and document the risks and benefits of taking these medications at the same time;

i. Respondent failed to discuss and document with Patient DM the aberrant urine toxicology result in August 2013;

j. Respondent pre-dated controlled substances prescriptions.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts and/or Excessive Prescribing of Controlled Substances, and/or Prescribing Without Appropriate Examination Based on the Care of Patient JG)

88. Respondent is subject to disciplinary action under Code sections 2234 [unprofessional conduct], 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 725 [excessive prescribing], and/or 2242 [prescribing without appropriate examination], in that Respondent engaged in unprofessional conduct in her care and treatment of Patient JG. The circumstances are as follows:

89. Respondent treated Patient JG, a then 33 year-old male, from September 10, 2012 through October 4, 2014 for fibromyalgia. Throughout her care of Patient JG, Respondent prescribed 30 mg of oxycodone, approximately 180 pills per month.

90. On or about September 10, 2012, Patient JG went to Respondent for care of his fibromyalgia. Under the chief complaint portion of the progress note, Respondent wrote "sleep issue/pain aching/stiffness," the pain was in his neck, elbows, ankle, knees, and possible upper and lower back; however, much of Respondent's handwriting is not legible. Patient JG also reported that he was in a car accident two months prior to the appointment and had right thumb pain when extending backwards, but the x-ray was negative for any medical issues. His current medications were listed as 30 mg of oxycodone three times per day, up to five per day. Respondent wrote she prescribed 30 mg of Oxycodone (150 pills) for three months for Patient JG's fibromyalgia. According to the pharmacy records, Patient JG filled a Norco prescription for 450 pills. Respondent did not discuss or document the risks and benefits of using high doses of controlled substances, particularly when starting the patient on a high dose of opiates.

Respondent did not review any prior medical records to confirm a diagnosis, conduct a urine toxicology screen, order any diagnostic testing, or conduct any assessment of possible addiction or use of illicit substances.

91. Respondent next saw Patient JG on or about December 7, 2012 for a follow-up appointment. The patient reported a cough and headache as his chief complaint and that his pain was controlled while taking Oxycodone. Respondent refilled the Oxycodone for three months.

92. Between March 8, 2013 and October 4, 2014, Patient JG saw Respondent every month with the exception of March 2014.[28] Each month she regularly prescribed Patient JG 30 mg of Oxycodone between 180 pills to 228 pills each prescription. Patient JG also prescribed 30 mg of Oxycodone 180 pills in March 2014 despite there being no progress note to support the prescription. During this period, Patient JG reported during his visits that either his pain improved, he was sleeping better, his pain was controlled, or that he had no new pain. Despite continued reports that Patient JG's pain was controlled, Respondent never discussed or documented reducing the pain medications.

93. Respondent began having Patient JG complete the two page "Patient Comfort Assessment Guide" in April of 2013. However, the second page was not dated and the records were not kept together making it impossible to determine which forms belonged to which progress notes. Additionally, the information completed by Patient JG each month is identical. For example, the same words for describing his pain are circled on each form, the same pain levels are circled, including crossing out the number five on two questions regarding how much in the past week pain had interfered with his life. Patient JG also wrote the exact same thing for "what makes your pain better? My meds" and for "what makes your pain worse? On my feet, and if no meds" on every single assessment. The only difference between all of the forms is the handwriting of the date on the first page of the forms.

94. During Respondent's treatment of Patient JG she never reviewed CURES reports or referred Patient JG to any specialist, particularly a pain specialist. Respondent never documented

[28] On May 3, 2013, Patient JG completed a "Patient Comfort Assessment Guide"; however, there was no associated progress note located in the patient's medical records.

any functional treatment goals for the patient or that she evaluated the efficacy of the medications, with the exception of his pain level when he was and was not taking Oxycodone. Moreover, while Respondent documented in many progress notes that his pain had improved, his identical statements and documentation on the "Patient Comfort Assessment Guide" appeared to indicate that his pain levels were interfering with his life.

95. On or about October 3, 2014, Patient JG saw Respondent for the last visit documented in the medical records provided by Respondent. He reported that his pain was controlled with medications. On the pre-printed progress note Respondent only marked an x next to systems that were not checked (including neurological and musculature) and then she placed a slash mark next to the other systems that were checked; however, Respondent did not add any additional information from her physical examination. Respondent refilled the Oxycodone for 35 days.

96. Respondent's care of Patient DM constitutes unprofessional conduct through gross negligence, and/or repeated negligent acts, and/or prescribing without an appropriate examination, and/or inappropriate/inadequate medical record keeping, and/or excessive prescribing of controlled substances, including, but not limited to the following:

a. Respondent prescribed large amounts and high doses of opioids without adequate or appropriate prior examination or a medical indication;

b. Respondent failed to document conducting screening measures before prescribing high doses of controlled substances;

c. Respondent failed to conduct a review of past medical records or CURES reports to determine the necessity for starting Patient JG on high doses of controlled substances;

d. Respondent failed to conduct and document any history of possible addiction or substance abuse history from the patient;

e. Respondent prescribed 270 times above the morphine equivalent dose (MED) per day and failed to thoroughly screen and monitor Patient JG;

f. Respondent failed to refer Patient JG to a pain management specialist, despite prescribing him high doses of controlled substances;

g. Respondent failed to establish and review any functional goals of her treatment of Patient JG;

h. Respondent pre-dated controlled substances prescriptions.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Patient Records re: Patients JC, AN, DM, and JG)

97. Paragraphs 25 through 96 are incorporated herein.

98. Respondent is subject to disciplinary action under Code section 2234 [unprofessional conduct] and 2266 [failure to maintain adequate patient records], in that she demonstrated unprofessional conduct and failed to maintain adequate and/or legible documentation of patient history, physical examinations, and/or the rationale for prescribing narcotics and other medications for Patients JC, AN, DM, and JG.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A53882, issued to Josephine Pham, M.D.;

2. Revoking, suspending or denying approval of Josephine Pham, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Josephine Pham, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: July 25, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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